

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-001036

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 119 Primary Registration District No. 5993 Registrar's No. 6

FILED FEB 5 1963

VS 300  
Rev. 4/59

6370

6700

3

4 0

5 1

6

7 0

8 2

94200

10

11

12 86-0

13 1-0

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Gasconade</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Montgomery</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		c. CITY OR TOWN <b>Rhineland Mo</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Frene Valley Nursing Home</b>		d. STREET ADDRESS (If outside, give location) <b>Rhineland Mo</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Hoffmann</b> Last		4. DATE OF DEATH <b>1-28-1963</b> Month <b>1</b> Day <b>28</b> Year <b>1963</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6-2-1878</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rhineland Mo</b>	
13a. FATHER'S NAME <b>Chris Hoffmann</b>		13b. MOTHER'S MAIDEN NAME <b>Johanna Tohlmann</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		17. INFORMANT <b>Henry Glee Rhineland, Mo</b> Address	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerosis</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>5:10</b> a.m. <b>P.M.</b> Month, Day, Year <b>6-15-51</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <b>Hermann, Missouri</b> COUNTY <b>Missouri</b> STATE <b>Missouri</b>	
21. I attended the deceased from <b>6-15-51</b> to <b>1-28-63</b> and last saw her/him alive on <b>1-25-63</b> Death occurred at <b>5:10 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED <b>1-31-63</b>	
22a. SIGNATURE (Degree or title) <b>Carol T. Shaw, M.D.</b>		22b. ADDRESS <b>Hermann, Missouri</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1-31-1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St Joseph Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Rhineland, Mo</b>
24. FUNERAL DIRECTOR <b>D B Baker New Florence, Mo</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>1-31-63</b>	26. REGISTRAR'S SIGNATURE <b>Delma Uffelman</b>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed D B Baker

Licensed Embalmer No. 3375

P. O. Address New Florence, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.